Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL207059402M
Compliance #: HL207058501C

Date Concluded: March 18, 2025

Name, Address, and County of Licensee Investigated:
Emerald Crest of Minnetonka
13401 Lake Street Extension
Minnetonka, MN 55305
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Peggy Boeck, RN, Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility abused a resident when several staff failed to follow the resident's plan of care. Staff forced the resident to change clothes and used a mechanical lift with one staff to transfer, which left bruising on the resident's hands, thighs, and arms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The facility trained the unlicensed staff to follow the resident's care plan and to report all falls. The resident had an unwitnessed fall three days before the report of bruising. Although the staff used a higher level of assistance for transfers, it could not be determined if the resident's bruises were from the fall or from staff using the mechanical lift contrary to the service plan. There was no evidence staff forced the resident to change clothes.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family, spoke with other residents

and another resident's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed the facility, resident's apartment, and staff/resident interactions.

The resident lived in an assisted living memory care unit due to diagnoses that included dementia and atrial fibrillation. The resident's service plan included assistance with toileting every two hours and dressing/undressing. The resident's assessment indicated she required assist of two staff for transferring, one with a gait belt, and the other for stand-by assist.

An internal investigation report indicated a nurse followed up on an unwitnessed fall report from three days earlier and observed bruising on the resident's thigh and tops of both hands. The report indicated the resident told the nurse that staff forced her to change clothes and grabbed her hands to use the sit to stand mechanical lift. The report indicated upon admission (six days earlier) the resident required a sit to stand mechanical lift for transfers. A physical therapy/occupational therapy assessment conducted several days after admission, changed the care plan to a lower level of assistance to include transfers with a gait belt and two staff. The investigation report indicated staff did not implement the change in transfer and continued to use the higher level of assistance sit to stand mechanical lift for transfers. The investigation report concluded that bruises could have occurred either due to the unwitnessed fall or staff not following the plan of care for transfers.

During an interview, a nurse stated the resident had no additional injuries or pain related to the fall or cares. The nurse stated the resident did not recall falling and had a history of refusing to allow staff to place the gait belt for transfers. The nurse stated she directed staff to reapproach the resident when she refused to allow the gait belt.

During investigative interviews, multiple staff members stated the resident was new to the facility and initially required a sit to stand mechanical lift for transfers. The staff stated they were not aware the residents care plan had changed to two staff assist with a gait belt for transfers until questioned about the resident's fall.

During an interview, the resident stated she did not recall any incident that would have resulted in bruising. The resident indicated some staff were nice to her and good about providing cares. The resident expressed some concern about staffing, as it took a while to get staff to help her use the bathroom.

During an interview, a family member stated the resident bruised easily due to her medications. The family member stated he could understand if the bruises came from the resident's fall at the beginning of the weekend.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility provided education to all staff to read and implement the residents' care plans prior to providing care. Four staff who provided cares, but did not follow the updated care plan received written warnings in their personnel file.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20705	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF MINNETONKA	13417 LAKE STREET EXTENSION MINNETONKA, MN 55305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On March 13, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL207058501C/#HL207059402M. No correction orders are issued.	0 000		